WRITTEN TESTIMONY OF MAUREEN A. CIAROLLA
Daughter of John J. Ciarolla
Veteran died July 18, 2011

September 9, 2013

Good morning. Chairman Miller and distinguished members of the Subcommittee, I want to thank you for the opportunity to testify here today on behalf of my family regarding the VA Pittsburgh Legionnaires' outbreak. My name is Maureen Ciarolla. I am the eldest daughter of John J. Ciarolla, a United States Navy veteran who died from *Legionella* while residing in the VA Pittsburgh Healthcare System (Pittsburgh VA). I would like to note that our father is listed as one of the "probable hospital acquired" cases, due to having two family afternoon visits during the "2-14 day" incubation period. At our meeting with the Pittsburgh VA on March 12, 2013, we were told as such in that because of that fact we couldn't scientifically prove he acquired it at their facilities.

First, we would like to thank all the employees and staff at the Aspinwall facility who were very kind and professional while our father was there. We would give special thanks to Ms. Connie Coble-Roe, CRNP, (Certified Registered Nurse Practitioner), who we spoke to often about our father's on-going care and well-being, and also Ms. Heather F. Korpa, LSW Social Worker, who our father spoke about with great regard, in fact our brother remembers our father describing her as, "a Good Egg." We would like all of them to know our appreciation.

Our father entered the VA Pittsburgh Healthcare System on January 22, 2011, became a resident at the H.J. Heinz facility here in Aspinwall and died six months later. I want to make one thing very clear - while our father was in the Pittsburgh VA we were actively involved in his life and his medical care. As a matter of fact, there is a notation in his medical records, in fact "warning" that the "family is very involved with medical care."

Why we are here today has nothing to do with the people who work directly with the veterans like those I spoke of. We are here today as family members who lost a loved one, to take part in the continuous effort to find how and why this *Legionella* problem got so out of hand here in Pittsburgh causing our father and other veterans to die prematurely, obviously. There can be no more tolerance for the tactical usage of stonewalling, red herrings and we should reject any evasive responses to questions and compel a lucid answer by all means necessary. My testimony today is meant to ask for your help in demanding clear answers to questions and that those responsible are held accountable, for real. The families of the victims, the families who lost their loved ones and all veterans are at least owed that much.

This micro pandemic, if you will, in the VA Pittsburgh Healthcare System was predictable. In fact, in 2008, top ranking VA officials, some who are here today, were informed that this very situation was going to happen. If for whatever reason they weren't aware prior to 2008, they should have known this was going to happen in the near future. At one time, the VA Pittsburgh Healthcare System had the leading Legionnaires' research facility in the world called the Special Pathogens Laboratory. In 2006 an administrative decision was made to close this research department and destroying decades of research in the process. This decision was deemed so bizarre and irresponsible that Congress had a hearing over this very matter.

Five years ago, to the date, on September 9, 2008 a hearing was held by a Subcommittee on Science and Technology. The subject was about how the lack of a coherent policy allowed the Veterans Administration to destroy an irreplaceable collection of *Legionella* samples. This report is public record and took place three years before our father contracted this fatal pathogen at the Pittsburgh VA. The information and discussions in that hearing record is the very reasons why we say this *Legionella* mess was indeed predictable. Here is what the report states:

> "The collection of materials destroyed in Pittsburgh was the work of Dr. Victor Yu and Dr. Janet Stout, who have, during the last three decades, become world-recognized experts in identifying legionnaire's disease. Dr. Stout is widely recognized for her work in developing methods to keep *Legionella* out of water supplies at hospitals and nursing homes. Dr. Yu has an international reputation for his work on infectious diseases in hospitals."

Think about that, they had the most knowledgable people in the world on *Legionella* and basically showed them the door.

Michael Moreland, I believe, was the incoming Director of the VA Pittsburgh Healthcare System at that time. The record goes on to say that he and Associate Chief of Staff for Clinical Services, Dr. Mona Melhem oversaw the decision to close down the nationally acclaimed Special Pathogens Laboratory and ordered the acrimonious destruction of *Legionella* and other disease isolates and also water samples containing the *Legionella* bacteria that had been accumulated by Drs. Stout and Yu over the decades of their research on this disease.

Let's think about that for a moment. Decades of research accumulated by the world's most renowned specialists just tossed out the door. Your decision as the incoming director to close down a research laboratory of that caliber in his own hospital has to be the most incompetent decision any incoming person could make. These were the top people in that field. By all reasonable accounts they would have been the first responders the moment before this deadly bacteria reached this critical stage.

The Subcommittee's investigative report points out further, that:

1. After "months of investigation … the Subcommittee have not revealed any credible reason for the destruction of the collection."

2. What was also evident was "that administrators at a major VA hospital had allowed personal animosities and goals to overcome its own processes."

Was there really animosity and goals involved there like the committee suggests?

3. Mr. Moreland and other witnesses from the VA should remember that their testimony today is under oath and it is simply not credible that important technical decisions were made entirely based upon conversations with no documentation.

If Mr. Moreland's testimony wasn't deemed credible back then, before deaths ensued as a consequence of his decision, how credible can his testimony be after this disaster?

4. The record continues, "I cannot imagine the circumstances under which a federal health agency official would unilaterally order the destruction of human tissue collection without receiving the approval of the agencies research office and the Research Compliance Committee. I cannot imagine why that official would apparently make false statements during the destruction to keep the Associate Director for Research at the center, in the dark until the destruction was complete."
5. When Dr. Stout was questioned about the need for ongoing research - because, these bacteria keep changing, so as to stay ahead of it, she states: "And if I may just add, in addition to therapy and treatment, we are also and have been for many years trying to put the tools in the toolbox to prevent the disease, which includes treatment of water distribution systems with various methods to control the presence of the bacteria in the water, and just like with antibiotics, there is no perfect solution so we continuously do research to perfect those techniques." She goes on to say "In the September issue of Clinical Infectious Diseases, there is a report demonstrating that there is an increase in

the incidence, or the number of cases of legionnaires' diseases that have been noted" and she attached the report to her testimony.

Dr. Yu testified that "microbes are evolving and antibiotic resistant is now a major problem" and two days prior to the sample destruction they received commentary from one of their colleagues in France. "They believe that *Legionella* has the capability to evolve resistance to Levofloacin, and they wanted us to test their hypothesis with the organisms that we had in our collection."

6. And finally, one subcommittee member commented that "all of us may pay a price for this conduct, veterans most of all, because the Nation lost one of its leading research labs on hospital infectious diseases."

Well veterans did pay a price. The Center of Disease Control and Prevention's report to the U.S House Subcommittee on Oversight & Investigations at its hearing held in Washington DC on February 5, 2013, states in fact that 32 cases of Legionnaires disease were diagnosed at the Pittsburgh VA between January 1, 2011 and October 21, 2012. It verifies the Pittsburgh VA's claim - that only five patients definitely caught Legionnaires' disease while hospitalized at the Pittsburgh VA. But it also suggested that sixteen additional patients "probably" caught the disease at the Pittsburgh VA.

Prior to the release of the CDC report the VA was claiming that there was only one death. Only after this report were they compelled to come clean. There were at least five.

We don't know nor do I think we will ever know how many victims there were in the past or that exist today. They definitely chose to remain careful and quiet about this. In our case, on July 15, 2011, we were adamantly told by Tiffany Pellathy, our father's Critical Care Nurse Practitioner

and Dr. Gilles Clermont, and I quote "*Legionella* had nothing to do with our father's condition; we treated and cleared that up with antibiotics, before he was put on the ventilator".

Additionally, I would like to point out the testimony from the February 5, 2013 hearing:

- Mr. Aaron Marshall, Operations Manager for Enrich Products, Inc., which supplies copper-silver ionization systems for the control of *Legionella*, testified that in June 2012, he was called in at the request of the Pittsburgh VA, to perform a review of the copper-silver ionization system and its operation at the University Drive facility, but that critical data was withheld from them. He testified "I requested but was denied access to view the *Legionella* test results." He also states "Had Enrich Products been aware of the presence of *Legionella* or Legionellosis cases at the VA University Drive Campus, we would have recommended implementing the reactive course immediately." He also said that they learned through the media that there were reported cases of Legionnaires Disease at the Pittsburgh VA and that there were deaths as a result, and there were quotes that offered doubt on the efficacy of copper-silver ionization. He stated "Copper silver ionization is an effective method of controlling *Legionella* bacteria. However, in order to maintain its efficacy, the installed system needs to be properly maintained and regularly monitored. And through today, (February 5, 2013) the VA has not shared its *Legionella* testing data or results."
- Mr. Steve Schira, chairman and CEO of Liquitech, Inc., the company that manufactured the Pittsburgh VA's *Legionella* prevention equipment, in his prepared statement he says: "While we continue to improve the technology, it is not plug and play. It requires regular maintenance, monitoring and validation. We have had some customers who experienced a re-occurrence of *Legionella* months

or years after the installation of copper silver ionization, it was simply a matter of maintenance and, if LiquiTech was notified, we were able to correct the problem and eliminate the *Legionella* bacteria within 24-48 hours once action was taken."

He goes on to say that the "outbreak at the Oakland Pittsburgh VA could have been prevented with standard maintenance and open communications." There is no question the VA should have taken more assertive action. This outbreak would have been avoided with proper maintenance of the copper silver ionization disinfection systems.

Think about this: you eliminate the world renowned Legionella experts, whose life's work is all about preventing, eliminating and treating those that contract the deadly bacteria. When you ignore the procedures and the advice of the product's manufacturer that helps keep the bacteria in check. If he eliminated the advice and work of these people then the disaster is also predictable. Who was Mr. Moreland getting advice and counsel from?

Under Mr. Moreland's watch, adequate policies and procedures were either disregarded or non-existent, warning signs and recommendations were either ignored or considered insignificant and there was certainly a complete lack of communication and/or requests for help according to the water systems' experts. To ouster the best minds on Legionella out of your company and disregarding the advice from the water system manufacturer while knowing that the deadly bacteria, *Legionella*, was lurking in the water systems at the Pittsburgh facilities has got to be one of the most incompetent decisions ever made. If you read the record of that 2008 hearing and all that was discussed there, it should be criminal.

We attended the hearings in Washington DC over this matter. There Mr. Moreland had no prepared statement and testified to that Sub-Committee that he didn't know too much about the

issue or "that it's complicated," all to evade the questions that were posed. In fact he testified that "he first became aware there was a concern with Legionnaires at the Pittsburgh VA in fall of 2011." Apparently Mr. Moreland was clueless in 2006 about the *Legionella* bacteria generally, attending the 2008 hearings over that decision that led to the hearing and didn't learn a thing, and he was still clueless about the *Legionella* issues in his own facilities in 2011.

As an example, the Veterans Affairs Office of the Inspector General issued two reports: one in April and one in July, 2013, finding that the Pittsburgh VA had:

- Inadequate maintenance at all times of the copper-silver ionization system
- Failure to conduct routine flushing
- Failure to test all patients with hospital-acquired pneumonia for *Legionella*
- Inadequate testing requirements
- Utilizing loopholes in reporting Legionnaires to the CDC, state and county health agencies

Like I said, this situation was predictable. If it was indeed predictable, then casualties were imminent. If deaths were imminent, then that had to be acceptable to those responsible, knowingly. Mr. Moreland and his administration regime knew that the water system at these facilities had a *Legionella* problem, eliminating a diligent water monitoring scheme, obstruction of investigations and the misleading of families and agencies was no less than gross negligence and gross misconduct or absolute incompetence, either way a deliberate gamble - and veterans paid the price and lost their lives over it. There is no other way to look at it.

Dated: September 2, 2013